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Is discontinuity of care undermining our response to domestic violence and abuse?

Domestic violence and abuse (DVA) is common and destructive, but tragically under-detected in primary care. DVA is relevant to healthcare professionals, because it corrodes the physical and mental health of those affected. The impact of DVA is trans-generational, damaging the life chances of affected children. People affected by abuse are more likely to be in contact with the health service than any other agency. A study of women attending general practices in East London found that 41% had experienced physical or sexual violence in their lifetime and 17% in the past year¹. Survivors identify doctors as someone they would disclose to, and general practitioners can be a crucial source of support.

Domestic homicide reviews identify fragmented care as contributing to tragic outcomes². Continuity of care is a multifaceted concept, with relational, informational and management components. Despite its complexity, continuity of care remains an ideal in general practice. This ideal is challenged by modern service organisation and working patterns. The proportion of patients who usually see their preferred GP is falling. Research links continuity with improved patient satisfaction, treatment concordance, and admission avoidance³. However, the importance of continuity to safeguarding warrants greater attention.

Relational continuity is typified by an enduring doctor-patient relationship. The patients that particularly need and want relational continuity are a vulnerable group, characterised by complex problems and social disadvantage. These are the patients most at risk of DVA. Feder *et al.*, in a meta-analysis of qualitative studies on DVA, found that survivors of DVA want continuity of care⁴. Vulnerable patients often lack the agency to ensure regular contact with their preferred doctor. This indicates an inverse care law, whereby patients with the greatest need for continuity are least likely to receive it.

The difficulty vulnerable patients have in establishing an ongoing relationship with a GP may contribute to under-detection. Doctors need time to see into patients' lives, and build a cumulative picture of concern. Patients need time to trust a doctor, and build the courage to disclose. However, closeness may cause doctors to miss an insidious presentation of dysfunction, or fuel dependency. Furthermore, familiarity only generates trust if previous experiences engender confidence. Given the complexity of relational continuity, strategies to promote it are contestable. Continuity with a preferred GP may be more relevant than continuity with a pre-specified GP. Following disclosure, patients could be offered follow up with the GP they disclose to. Indicators of DVA, which GPs use to target enquiry, could indicate a need for relational continuity. The burden on one GP could be reduced by encouraging the patient to see a small subset of GPs.

Informational continuity is ever more important, as care is shared between clinicians. Poor documentation has been a consistent theme in domestic homicide reviews. New national guidance provides welcome clarity about how to document DVA in primary care, without putting patients at risk⁵. A safe and consistent approach is increasingly important, as patients gain online access to their medical records.

The response to DVA must be multidisciplinary, because the issue is relevant to criminal justice, social care, housing, education and health. Multi-agency risk assessment conferences (MARACs) provide an opportunity for coherent management, but unfortunately cases do not always reach the

threshold for mandatory intervention. Specialist DVA agencies are crucial to a coordinated response, irrespective of risk threshold. Patient engagement is strongly influenced by the way GPs facilitate contact, and referral is far more effective than signposting.

Discontinuity of care is potentially undermining our response to DVA. GPs can be powerful advocates for vulnerable patients, but are subject to immense system constraints. GPs are asked to deliver ever more, and realism is needed. Possible solutions include offering patients follow up with the GP they disclose to, documentation in accordance with RCGP guidance, and proactively referring patients to domestic violence agencies.

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